TABLE OF CONTENTS Page 1

GENERAL MEETING FEEDBACK

Lacey

1. It would be nice if these meetings could be offered in more locations throughout the state and only last ½ day. It's expensive for the travel and time cost.
2. Thank you for finally having this "Regional Meeting". It really helps communication and understanding between First Steps providers and what the state program really wants to communicate. It also allows us to give direct feedback about how changes impact us and our clients out in the "field."
3. There is great opportunity for clarification that happens best face to face.
4. Also, love the networking opportunities with other agencies and state staff.

Spokane

5. A knit free zone. Seems somewhat unprofessional. ☹
6. I so much appreciate that state staff listened to input from county providers in decision making related to what services CHWs could provide.
7. This room was good. But parking was a problem. It was hard to find the room when the building was not identified. We finally stopped to ask.
8.

Moses Lake

9. How about tapping the funds of pharmaceutical reps (e.g. birth control pills, devices, methods) pregnancy and infant product companies and others to help sponsor the cost of the meetings, lunch, materials, etc.
10. Avoid abbreviations i.e. BI include Billing Instructions wording. QI Framework

Burien

11. For practitioners-application is most critical.

Lynnwood

12. Have box lunches and ask people to pay for them. Many of us can be reimbursed for lunch.
13. There is much more benefit to the front line workers to hear other providers' comments, solutions, problems. Please don't read your PowerPoint to us. We can all read. Too much DATA!!
14. Idea for Regional or First Steps Meeting --off 41st street exit in Everett. (right off freeway I -5) Large log building (part of Everett Parks & Recreation) great atmosphere, state area, large kitchen, etc.
15. Get First Steps web-based.
16. This is what I learned today: Good news: The state is interested in what First Steps providers have to say about what is working or not. Bad News: "It's complicated", "We're poor" and "Change is slow".

Access to Prenatal Care, Is There a Crisis? And Reaching the High Risk Women Presentations
Questions and Comments

Lacey

1. Average # of visits is very skewed by clients who receive a large # of visits. Knowing the % that receive 1 visit, 2 visits, 3 visits or 4 or more is more helpful in understanding impact of interventions. Would like to see how this compares for the 3 groups.
2. Would FS data systems consider collecting breastfeeding information? We have good WIC data but that doesn't capture every woman. Questions like "Did the MSS provider encourage, support and educate about breastfeeding – especially PP. Did having MSS make a difference in breastfeeding success?"
3. Can you look at other outcomes besides low-birth weight? How about all the other great services MSS provides like improved living situation, education help, receiving counseling services, enrollment in CBE classes? Also would be interesting to note fewer "emergency" false labor visits by MSS clients vs. Non-MSS clients.
4. Has an analysis based on the number of children been conducted? TANF assumes multiple children S-women could be 1st pregnancy. Could this be a barrier to care? Reason for late access of TANF women, since thy already have Medicaid and coupon.
5. I would like to see the data specific to county on Barriers to Prenatal Care Entry – slide. (With reasons for Medicaid/non-Medicaid)

Spokane

6. While smoking rates among pregnant clients in Asotin County are high, some professionals suggest that these numbers are 25-35% higher. This suggestion relates to the fact that smoking in pregnancy is not socially acceptable and that these numbers are self-reported.

Moses Lake

7. Regional data would be useful. The reasons women state why they entered care late are important. How can we design plan to increase early entry into care if we only have the info for the largest counties?
8. At Yakima Neighborhood Health we have DSHS out stationed employees who assist with Medicaid enrollment.
9. County data for Yakima county, I would like the details of why women had no or late prenatal care, if county data is not available.
10. Why have long term birth outcomes not improved over the last decade?
11. How can we get a valid count of the migrant women in counties where we have a lot of agricultural workers arriving for harvesting of different crops? These women may not access prenatal care until near due date or at delivery.
12. I question the validity of using mother's recall of start date of her prenatal care. At our home visits, it seems that most-many women are "guessing" at the date they began prenatal care. Why don't you get the date of the first billed claim?
13. Regarding risk factors such as DV not being accounted for…If there was some method of data collection for our 1st Steps risk factors you would have that info as opposed to it just sitting their charts.
14. I read in a March of Dimes study that said 55% of all LBW babies not associated with other risk factors are related to domestic violence. Was that factor looked at?

15. Yakima Co.—accessing medical care in 1st trimester. We have clients that are new to this country, many/majority from Mexico, that begin care here. At times, they might have seen a Dr. /mid-wife once in Mexico, that would throw Yakima county #s off?
16. Yakima co. is a high-farm labor area where we do have OB that move due to needing work to survive. Many are undocumented and therefore cannot be TANF recipients YET not until they have a baby born here that can get a SS#, only then can they access TANF or food assistance benefits. This would also throw off our #s for Yakima Co. How is this tracked?

Burien

17. King County First Steps network is planning a short survey of 2-3 weeks duration of gathering reasons clients identify re: why AP care was not started prior to 16 weeks of pregnancy. The reasons we are using are similar to that on your PRAMS data slide. Is it worth it for us to continue with our survey plans if they are duplicating what is gathered by PRAMS surveys?
18. "I didn't know it was important." "I didn't know coverage was available to me." These are not listed as "reasons" on the presented chart; however, I suspect they may be more significant than all of the listed reasons.
19. Although statistics fascinate me, for many here a quick summary of research that leads to "How does this impact how we serve women?" would be time best spent.
20. Is there credible data linking late (second –trimester) OB care and poor birth outcomes?
21. Where do we find the state definition for high risk?

Lynnwood

22. You are invited to come to Snohomish HD to review data and do health planning
23. Why are "we" held accountable for declining rates when a big part of the problem is lack of providers? We have a Dr. who delivers @ 36 weeks + 5 days in order to decrease his work load!
24. Question—Our number of miscarriages in our counties. Benton/Franklin counties are higher than ever. Why! Most clients are agriculture based and exposed to pesticides either by partner or self, there is LITTLE work (advocacy) education in this area by First Steps.
25. Address limited housing options.

PROGRAM REQUIREMENTS & UPDATES PRESENTATION COMMENTS & QUESTIONS

Case Conference

Lynnwood

1. MSS Case conference requirement: How do MSS providers do this when services are provided in a clinic setting? Give examples in the Manual.

Charting & Documentation

Burien

1. I am charting as OB Coordinator in an EMR then double charting on paper for MSS Anything coming up to put MSS charting to computer? Other disciplines click radio buttons for pt. teaching, well child checks. For example – this would improve charting, data collection and data interpretation by making it more efficient.
2. Minimum requirements = 16. RF = 16. Can these Minimum Requirements and Risk Factors be numbered the same for ease in documentation and for use in Omaha system?
3. Specify--include reinforce breastfeeding the paperwork/charting. In outcome/discharge align questions with services rendered. Ask about how long breastfed…put to bed with bottle—add this to client visit record.
4. Add to CVR – folic acid pre-pregnancy.
5. DOH/DSHS to look at the correlation between the new paperwork requirements and the decrease in the # of visits and decrease in the relationship between MSS clients and MSS providers.
6. With WIC implementing the new VENA question on Jan. 1 – there are many duplications between the VENA questions, the MSS screening tools, and the professional assessments. Can't WIC and First Steps work together so this duplicate info gathering from different programs won't occur?

Lynnwood

7. Please do something about redundant forms!
8. The "new and improved" paperwork is VERY time consuming. It's not very useful or clinically relevant. Doesn't flow well. We spend A LOT of time completing required paperwork. This is time we could spend doing patient care.
9. I have to agree that the redundancy of the MSS paperwork terribly counter productive. Need to focus more on the health messages and the OUTCOMES.
10. High case loads---documentation on paper are barriers.
11. High case load and increased amount of paperwork.

Coordination of Care/Duplication of Services

Spokane

1. Redefine i.e. Duplication of services. Double billing. The term Coordination of care confusing. Billing is an audit issue. Could be captured through a billing process "flag" to send an audit if MSS billing coming from multiple providers.
2. Service Duplication
    a. Connect FS provider to client registry. Housed in RDA but not research

Burien

3. Snohomish County helps SO much in avoiding duplication of services. Could King County have a similar "clearinghouse"?
4. Multiple providers MSS/ICM –unintentional. A client changes WIC location MSS initiated at first WIC. Client doesn't understand she is receiving MSS/ICM at 2 locations.
5. MSS/ICM Provider must be alert o client receiving WIC at another location and CALL TO CLARIFY.

Lynnwood

6. It will be helpful to have a guideline. And share w/other agencies.
7. In Snohomish County we have an understanding with all FS Providers that share referrals/clients through Snohomish Health District. Many of our clients also having MSS through Seattle clinics – we never know.
8. To the STATE—Please set up a system to find out (like WaMed for DSHS) what MSS agencies are involved with client. Enter password to site. Enter name client (B.D) and show providers involved. PHN, BHS, RD @ _____ agency. This is what we do to get PIC # for client on WaMed. Saves $
9. Label to put on I.D. card (low tech-like the commuter label sticks) with the of the MSS providers.
10. I believe that this is a state responsibility. A computerized state system would help to decrease the duplication of services!
11. Needs to be a computer type system to see if a client is being seen elsewhere.
12. State registry database: access online by pt. names/date of birth.

Home Visit/Office Visit (HV/OV)

Lacey

1. Is there a question on the satisfaction survey that asks the client's opinion on this? Our agency hasn't used the satisfaction survey so I don't know. Seems like this would be the place to find that out.
2. Also, home visits definitely alerts providers to potential and real safety concerns.
3. I believe that this issue should be left up to
    a. the judgment of staff,
    b. team conference based on client's receptivity and
    c. client's risk factors.
4. Assessment of risk factors and ultimately outcomes are better known with home visits.
5. A client feels more comfortable, less rushed and consequently more amenable to change.
6. When discussing home visits vs. office visit it is important to factor in attempted home visits and client is not home.
7. I suggest mandating offering both home visits and office visit but more flexibility between settings per client desire.

Spokane

8. As a long time FS provider STAFF (nurse), I'm an also late believer in the importance of home visits (David Olds) but if a client DOESN'T want home visits (& quite a few don't seem to)isn't a visit in the office better than none at all?
9. I have been in FS since 1990. I have seen huge changes not only in the program and delivery of services. 4 years ago we implemented office visit. I have seen it significantly and negatively impact the quality of services provided. Case loads have tripled 2 times without low reimbursements rates so office visits were started. The result for me has been faster client turnover, less therapeutic relationships, loss of quality of care. It has become very production unit collecting driven see more in office. Poor service is what I see.
10. Please do not eliminate the home visit requirement. We can obtain much information by just observing the home environment. We can obtain much information by just observing the home environment. We do offer the client an option for home or office visits. There are rare occasions when the client refuses home visits. The choice is client driven, but I think the provider must be required to provide both.
11. Our agency strongly supports home visits for FS clients. This is the ONLY way to assess the safety of home environment. Also clients miss fewer visits and open up speaking freely at home visits.
12. If clients are required to have a home visit I feel we will loose (sic) a significant amount of clients. I do feel a home visit is extremely important though, and the program should be presented as "we will make a prenatal and post partum home visit".
13. If CPS is involved of course they can not refuse a home visit.

Moses Lake

14. I believe 100% that HVs are effective and should be a part of the program.
    a. Biggest issue is COST. Reimbursement must include the agency's cost of travel time plus visit time plus gas cost.
15. There continues to need to be the option for a client to decline/opt out of home visits.
16. We have rural setting and driving out and having no-shows is a big issue. Our MSS no-show rate is higher than our now-show rate for our other programs. Cost vs. benefit.
17. It should be optional vs. mandatory.
18. With the increasing price of gas (and considering the issue of global warming) –is there any suggestion or idea of including any provision for having telephone visits --that are billable at some lower rate? Obviously, they're not as desirable, but they often have value.
19. I find that some of my clients would have a problem making appointments for the office.
20. Since limitations of access to transportation may be an issue for clients we often need to go to the client's home. Home visits are not a problem in rural communities!
21. I find that some of my clients would have a problem making appoints for the office.

Burien

22. Home visiting may decrease ability to reach some high risk women suggest meeting clients at Safeway, community centers, elementary schools, churches, initially---build trust then maybe providers will be invited into the home.
23. Is State considering increasing amount paid regarding the increased $ of gas. Note barriers of clientele for care means office visits only would decrease access to care.
24. I fear some high risk Moms wouldn't be motivated to get into office visits. Of course there are many reasons OVs would be environmentally superior and cheaper.

Lynnwood

25. Home visiting is beneficial to the women in whom we serve because transportation is such an issue; plus it allows for home assessments in which issues arise in which it couldn't be assessed in a clinic.
26. Evidence demonstrates home visit programs, such as nurse family partnership, yield long term changes—rather than episodic, more crisis oriented care more indicative of First Steps. The idea of NOT differentiating home or clinic services for requirements is appealing. Without strong evidence in the literature, this approach is valid.
27. Regarding home and office visit requirement—please focus on content of visit regardless of where visit occurs.

Infant Case Management

Lacey

1. I strongly agree that ICM should be based on need and education needs of parents. We have very limited resources in our community to refer to.
2. ICM:
   a. Eligibility reviewed
   b. Consents signed and paperwork started during MSS period OR when ICM starts (3rd month) Clarify.

Spokane

3. What constitutes or qualifies as "another program" (In presentation "Deferred = is receiving case mgmt in another program.)
4. Forms should state "Services were DECLINED" rather than "refused." Refused carries a negative connotation for a voluntary service being offered.
5. Is ICM eligibility determined prior to MSS closure? Or can it be assessed after MSS is closed? SI spends hours on phone calls to SW's, CPS, MDs, doing research, etc. This is all critical and unfortunately unbillable.
6. Give 40 units – more flexibility on billing. Not restricted to 6 units a month.

Moses Lake

7. Team evaluation first and fast intervention for ICM.
   a. Medical needs
   b. Social issues, such as domestic violence
   c. Behavioral issues such as post partum depression ML
8. ICM new babies sometimes do not receive medical coverage at end of (2 months) MSS ending and PHN has difficulty in billing. How do we bill the service as the result?

Burien

9. Increase ICM services to include the utilization of screening tools (Becks, Edinburgh) in order to effectively serve clients.
10. Increase services for ICM to include teaching, brief counseling and not limit the program to provide linkages only.
11. I find that ICM clients in particular require home visits almost exclusively, yet ICM reimbursement does not increase for home visits as MSS services does—why?
12. Realistic manageable ICM documentation.
13. ICM ONLY I wish we could do a BRAINSTORM more focused on ICM. (all day conference)

Lynnwood

14. It was mentioned that an ICM client with DV may need intensive early services such as referral to a shelter and being helped with forming a safety plan. Are you saying we can bill for assisting a client to form a safety plan, as this is not a linkage? It is however important.
15. ICM = Infant case MANAGEMENT. Case management should be that instead of providing resource. Can this be revisited? Change in this area is crucial to better outcomes (i.e. domestic violence cannot be resolved by a monthly appointment.

16. Design ICM so that certain ICM risk factors that require INTENSIVE ICM work RIGHT AWAY (with no 6 units/Mo limit) HAVE a different model of 40 U/ ICM period with THOSE UNITS be given free reign . for example DV issue
    a. Need to refer advocate, link women
        i. Shelters (often unavailable beds in One's county)
        ii. Centers for battered women
        iii. Possibly CPS
        iv. Transportation issues.

    6 units a month WILL NOT ALLOW appropriate interventions –goals—outcomes. Our current model does not help women with certain ICM risk factors.
17. Perhaps it would make more sense to put $ into nurse family partnership!!!
18. B-3, all we hear is how important this pt. it is---all we can do is outreach (to someone we already know) link to services that in many case are available in county.
19. Need to look at how units are utilized—high risk families—you can only do "outreach and linkage" 98% of the time you already know family from MSS—perhaps it would be better use of $ to spend time educating family.
20. Re. ICM--For a woman with post partum depression 10 1 hour weekly visits would be much than 6 units/month. There needs to be flexibility depending on risk factors.
21. When the criteria for ICM changed a few years ago it decreased effectiveness. It underutilizes the professionals working in the field that can help right then and there. I.e. ref to feeding clinic when the PHN/BHS has scale and expertise 5to help and follow up. I.e. breast feeding issues when PHN is IBCLC and can help.
22. ICM Caseload Issues: we would like to be part of a Focus Group.

Interdisciplinary Team

Lacey

1. What is being done to ensure that clients have equal access to all disciplines in areas (locations) where this could be provided but is not?

Orientation

Lacey

1. Check state list for agencies to assist new staff.

Lynnwood

2. First Steps "test" for new employees. Impossible to navigate and use.

Subcontracting

Spokane

1. How is subcontracting, case conferencing, interagency coordination, etc…impacted by HIPPA requirements?
2. What type of written contract, protocol, and agreement is necessary to subcontract
3. Do subcontractors then have their own training requirements?
4. What about a signed Provider Agreement?

Supervision

Burien

1. This requirement should be time limited – if I hire a BHS who does not meet experience requirements at hire and therefore needs clinical supervision, it stands to reason that after a year or two they would have sufficient experience to drop this requirement?

Training

Lacey

1. Will the training requirements be more like competencies where annual demonstration is documented?

Spokane

2. Does this mean on-going continuing education, initial training to do the job or both or neither??

Uncategorized comments

Lynnwood

1. Please do include evidence-based practice literature to help guide these requirement revisions.
2. Please put WAC online or in the First Steps manual for those who might not have access to computers.
3. How can we get informed on the 15 changes upcoming?

THINKING OUTSIDE THE BOX-Brainstorm Sessions
COMMENTS, QUESTIONS & SUGGESTIONS

GENERAL PROGRAM ADMINISTRATION

Lacey

1. How about just combining MSS AND ICM and call it Maternity/Parenting Support Services and just adopt the "rules" to cover both phases. This would eliminate a different coding and billing system—the info and education follow and continuum.
2. Please consider combining the programs—MSS and ICM. It would simplify and improve both programs SO much!
3. Hire recent new moms who have completed MSS program to work @ DSHS or CSO clinics to help new pregnant women get set up and used to the system. Peer to Peer, NOT professional. Will increase client interest and trust.
4. Since Children's Administration is completely redesigning ARS to be EFSS & ICM and MSS don't seem to be duplicate service can one agency—separate staff enroll clients in both First Steps and ARS/EFSS?
5. It is disconcerting to have state staff ask us how we can better reach higher risk clients when we are already reaching 90% of the populations.
6. The law regarding home visiting is specific to PHNs.
7. I believe First Steps has contributed to the decline in marriages.

Spokane

8. For client's clarification we need to use "one" term only throughout all agencies. I.E. First Steps – not MSS or other terms which confuse the clients. How about Healthy Mothers Healthy Babies—easier to comprehend!
9. Can MSS program afford to pay for services if Spokane County increases access to care to State level?

Moses Lake

10. If a client is high risk, such as gestational diabetic, we need more units to be able to see them monthly by the RD as required by our standards of care.
11. Cultural Competency. Hiring staff that is culturally competent and can speak the client's language has an effect on client response to MSS, especially when we are dealing with high risk clients such as depression, domestic violence, CPS involved, etc. Client will build trust and open up to their needs.
12. If your program will be giving incentives, be prepared for the BOOST in your clientele. Be prepared to have enough staff to provide services.
13. Units: As an MSW, visits last 2 hours plus, yet we can only bill 6 units for that visit. Working w/pre/post partum depression, my clients take "longer" visits yet I can only bill for 6 units.
14. What changes can I make in my workplace? Follow-up on clients that "decline" by doing a home visit or telephone call. Clients are offered MSS at Dr.s office when they have a positive pregnancy test, and other blood work…by the time we offer MSS, the client is at a "shut-off" mode. We need to offer and discuss MSS all by itself to relay the message more clearly when the client is only focusing on MSS.

15. The revised 15 minute definition has required staff to be "clock watchers" which is not in harmony with client centered counseling.
16. Could it be a "standard measure" like smoking cessation and family planning to talk about considering an adoption plan? The reality is it IS difficult to be a parent w/limited resources. Maybe it would be worth some of our moms considering adoption for this pregnancy and being better prepared (education, housing, work, transportation, etc.) for next pregnancy!
17. It sounds like there is agreement that prenatal care (Especially early in pregnancy) has a positive influence on healthy birth outcomes. Is there such a conviction about MSS enhancing this prenatal care and healthy birth outcome? If so, what is the barrier to a minimum # of MSS visits being required as well as prenatal care? If no needs identified, visits would not be continued. If there ARE needs, then clients would be in a position to more readily utilize services voluntarily.

Burien

18. Somehow extend programs through baby's 1st three years. There are programs to link them to I am aware, but trust building is huge through the maternity cycle and referring them out – most clients fall through the cracks – long-term support with 2-3 support persons in their life can make a difference long term.
19. Has our system created the practice of denying hospital bed rest for high risk pregnancies? Granted, we can get 2 pounders to survive but at what cost long-term?
20. Postpartum visits & Birth Outcomes: 5 out of 6 birth outcomes can be addressed postpartum (CPS, SIDS, etc.) no doubt they can be addressed prenatal as well – but postpartum visits are important.
21. Suggestion: Pilot effectiveness of higher reimbursement rate to First Steps providers (MSS/ICM) for visits with HIGH RISK MEDICAL and TANF clients.
22. I suggest Washington State First Steps program provide licensure supervision resources for BHS pursuing their licensure. This would include discounted rates for group supervision as well as individual supervision. It would be helpful to have licensure supervisors who had knowledge and expertise with MSS and the specific concerns of providing services to our clientele and families.
23. Have you looked at:
    1. whether or how the individual providers of MSS effect outcomes?
    2. what does the average MSS provider look like,
    3. individual provider matching or looking like the client – would or does this make a difference (race, age)
24. Would the state consider a "Pre-pregnancy" incentive program? A "Pre-pregnancy" program could address: improving health, changing behaviors, earlier and/or established medical care/providers, access to Medicaid assistance to compensate providers and encourage clients. Pre pregnancy care would decrease delay to access of care, increase general health and knowledge or pregnancy and increase opportunities for pregnancy planning.

Lynnwood

25. What supports are provided/available for those rural providers who are attacked/maligned by larger multi-county providers who stop at nothing short of driving all other providers out of the county? When will the state start supporting rural providers who are extremely dedicated to providing services to their community, but not at the expense of having their personal/professional/agency's reputation continuously attacked?

26. Some of our clients (very hi-risk) in which both the RNs and BHS see the client run out of units. 60 units are not enough. Sometimes with these clients the RN and/or the BHS do 1 or more "free visits" to meet the needs of the clients before MSS period is up.
27. We used to be able to petition for increased # of units (20 more) for very hi-risk clients. It would be great to have this again. Thanks!
28. Our county wants to drop the MSS program because of the cost – too much time is spent on clients that cannot be billed to program – i.e. travel to HVs, phone calls, charting.
29. If outcomes are better (statistically) then reshape services. Decrease # of available units for non-citizens and increase TANF MSS/ICM units for this group. Let's make sense of this data in a revised model of care!! This might be controversial but This might change our state's data!
30. A comment stated by Laurie Cawthon about how managed care plan saves money and the women whom are actively receiving managed care plans receive better care. Why can't, why aren't we moving towards universal healthcare to save money, and to increase healthcare to the WHOLE population. MANY many families and friends want universal healthcare. Healthcare is a right not a privilege!
31. If DSHS decides what monies are counted to make a person eligible, in a Military family the housing allowance is on the "LES" it's in the income column but the family never sees this money. It goes directly to Housing Dept. We need DSHS NOT count this $ when considering income eligibility.
32. With high risk MSS clients the 60 unit limit is sometimes too little especially when BHS and CHN are seeing. We need more units often.
33. Contact counties that are successful with MSS services. I.e. San Juan to see how they have accomplished their success.
34. Contact counties that have accomplished Health People goal, i.e. Wahkiakum to find out what their secret is/why they are successful.

GROUPS

Lacey

1. Groups as visits: also address transportation issues in getting to the group.

Spokane

2. Screening for depression seems critical to pregnancy and postpartum outcomes. If support groups are beneficial, and depression is a manifestation of underlying anxiety, it seems that group support, fellowship, shared experiences, etc…would have value for these clients. Offering concrete rewards and/or incentives for participation may be a way to increase self-esteem, self efficacy. Building relationships, focusing on connection is important in low socioeconomic populations with generational poverty.
3. At risk moms have anxiety issues and to resolve this we need to decrease social isolation. One idea have group OB visits.
4. While individualized services are very important in the FS relationship, it would be helpful to consider group encounters, classes, education, etc…In low socioeconomic populations and in communities with high rates of generational poverty, socialization is very important. Since these clients live together, travel together, socialize together, etc…it makes some sense to offer some type of group process (perhaps around a specific topic—for example, smoking)
5. There is a large demand and desire for group classes: cooking, parenting and breastfeeding but no way to bill for these. Can we find a way?

Moses Lake

6. Groups before and after the delivery. –family group. Topics: relate to increase the quality of life for all the family.
7. I believe it would be beneficial to hold groups for "holistic depression recovery for pregnant women who are not bipolar but high risk for manic depression or post partum depression.
8. FS needs to determine reimbursements for group services for some of the important FS required services and goals that are amenable to group. E.g. pre-natal and post partum depression and teens. Individual visits are important too!
9. There has been a lot of verbal support for groups. It has been my experience that TANF clients have a lot of requirements on them already. Groups may work in some communities but many times they are poorly attended in the smaller communities where transportation is also an issue.

Burien

10. We need to be able to have groups. CBE, Infant Care, walking groups and be able to bill for groups to increase awareness, increase community involvement and DECREASE ISOLATION OF NON-ENGLISH SPEAKING WOMEN, especially since they live in a different community than they see their care providers. For example, in north Seattle we are getting pts from Lynnwood and Everett, West Seattle is getting pts. From SeaTac, Tukwila, Federal Way. Regarding the mass exodus of people who can't afford to live where there are services.
11. If social support is beneficial during pregnancy and post partum we should have some means of having group work and getting reimbursed for it.
12. First Steps needs to find a way to reimburse provider agency for groups. We are missing out on the power of groups because there is no money involved with groups. Reimburse groups!!!!! Breastfeeding moms and post partum groups. B

13. See idea to make support groups billable—making groups, Mom support/resources.

Lynnwood

14. Where are we in looking at Group work being reimbursed? In past First Steps had trials with Groups that were presented at Regional meetings and appeared very successful and maybe less expensive.

Non-Citizen Issues

Lacey

1. Non-citizen pregnant women—who's household income is more than the eligible level are put on a spend down medical then that woman doesn't see or have prenatal care. She doesn't know what other option for getting medical insurance.
2. Non-citizens pregnant women are put on a spend down medical coupon (the non-citizen pregnant women 's partner might make more at that time, but less later)
3. Some non-citizen clients are receiving TANF after they have their babies here.
4. Non-citizens are many times receiving TANF benefits. How do you separate them?
5. Need Family Planning for non-citizens to go past the 1 year current for Medicaid. Take charge no longer for non-citizens. Where do they get birth-control?

Spokane

6. I agree with outcome/risk of poor birth outcomes for non-citizens. I work with a lot of Russian speaking refugees who are not yet citizens. They almost always have good size babies even though they may not get into prenatal care until later in pregnancy. Their nutrition is good during pregnancy and very rarely7 drink alcohol or use tobacco during pregnancy (or ever)!

Moses Lake

7. For our Non-citizens, more especially the high risk, late care, multi???? They need incentives to have MSS. The car seat program would be something that MSS can provide as a requirement to get MSS. So we in MSS can see them to get good care.

Burien

8. Community Health worker could go to churches, community organization, radio to provide info.
9. If non citizens are so low risk, why are we funding MSS? It's actually even more costly when you add interpreters.
10. Undocumented women are not eligible for mental health services.
11. Also, for Spanish speaking women – even harder to find care and no way to get medical coverage post partum. (mental health)
12. For non citizens – numbers could be low due to fears of Immigration
    a) Fear of getting stopped on way to clinic
    b) Lack of information regarding their rights
    c) Fear of "losing children" to government –if they access care
    d) Clients need information

PROMOTING the FIRST STEPS PROGRAM

Lacey

1. Clients get confused because some providers refer to their services as MSS while others refer to their services as 1st Steps. They may have 2 different nurses from 2 different agencies and don't even know it is the same program. Can't we decide on ONE NAME that everyone uses to describe FS? I think that will help clients know what program within they are enrolled!!
2. Educate hospital and billing offices about eligibility for FS so they can refer women to the CSO or even help them apply.
3. Marketing i.e.-busses, PSAs, TV ads, elevators, OB provider meetings, conferences, etc. i.e. *Pregnant? Need help? Ask about services for you.* Call Agency may type in ph #s, etc. DSHS office. I would be happy to help, time permitting.

Spokane

4. Develop pamphlet posted by stores/pharmacies with pregnancy test kits. To inform consumers medical insurance (state) coverage and the importance of 1st trimester care. S
5. For client clarification we need to use one term only throughout all agencies. I.e. FS – not MSS or other terms which confuse the clients. How about something easier to comprehend like HM/HB
6. Hispanic migrant pregnant teens are not open to talk about pregnancy. They are in denial. Prenatal education through the media, TV, radio could help increase importance of prenatal
7. Marketing – there seems to be very little. Agencies don't have FUNDING to do this.

Moses Lake

8. Update FS brochures to give out to all providers, schools, community agencies.

Burien

9. To address this lack of awareness, (importance of prenatal care and availability of coverage) I suggest including information on importance of and coverage for, prenatal care, in school health class curriculum. I suggest beginning with Jr. Hi classes, because many of our clients, especially highest risk, drop out before, or early in high school.
10. Education: With all the wasted time in waiting rooms of WIC, OBs, MW, etc. why not have videos playing in waiting rooms such as depression video shown today.
11. PSAs ON THE BUS with tear-off info cards!! English and Spanish AT LEAST. (Since they sit on the damn bus for hours and are bound to have read every sign 1000s of times!)
12. Increase knowledge of MSS program services and benefits to OB/CNM high risk providers. Develop working partnerships.
13. Reaching high risk women--Target AA women for service. Develop "army" of providers to do this work.

Lynnwood

14. PSAs (Spanish) would be beneficial to reaching consumers to get Prenatal care.
15. In addition to women needing education about the importance of early prenatal care, the proposed PSAs could include info about pregnancy medical and how to access that. It seems even after all these years. Many women especially nonTANF women don't know they could be eligible for pregnancy medical.
16. Ways to Prioritize Suggestions:
    a. Do we need a policy?

b. Do we need new/different resources?

If NO to both, let's make it high priority and figure out how to do it. Example: put First Steps brochures in pregnancy test areas and in non-traditional sites:

Community clinics, libraries, food banks, community centers, bus stops, bus adverts, phone muzak, ad with famous Seattleites.

17. Have Gov. Greg do PSA on early prenatal care.
18. The way women access information about pregnancy has changed – internet, TV, etc. but women all enjoy talking about their pregnancy and their lives. Program needs to keep up.

Requiring First Steps as a means to increase participation by TANF women

Moses Lake

1. Have requirements on TANF women that need visits or at least screenings.
2. All women on Medicaid coupons should be required to have a maternity screen.
3. CSO mandates an MSS screening and at least one visit.
4. Workfirst could count MSS participation in their 20 hours of required weekly activities for pregnant TANF recipients.
5. I think that TANF mothers should be required to attend MSS and post delivery follow up.
6. Dropping out of school. Young women are aware that the state will pay for a GED and childcare to their mom or aunt and so they leave school…wait it out. get all kinds of services. Educational programs seem out-of-sync with types of "jobs" actually available. Result: pregnancy is a ticket to pull back and wait for other options. Same old/same old. In this case, an example of unintended consequences to the availability of a wide variety of gov't services.
7. The program time requirements for TANF participants are very strict for them to continue to receive benefits without being sanctioned. BUT they don't allow time away for MSS/ICM participation. Need to give the TANF participant time and credit to participate in MSS/ICM appt. /home visits/ activities.

Burien

8. Is the workforce able to do the work with the population in need? Should the workforce make up reflect the communities we serve?

Lynnwood

9. Require MSS when client get Medical.

REIMBURSEMENT—COMMENTS & ISSUES

Lacey

1. Can we get increased funding for visits? Gas prices increase, our time costs our agency more.
2. We need increased reimbursement. As a hospital based non-profit we are still operating MSS in the red. We are doing better but can not budget provider administrative time or education days. A slight increase could bring us to break even.
3. SSI clients always getting denied (the agency) for services billed – for MSS. L

Spokane

4. If 71% of WA state Medicaid women are on MSS, why aren't we funded better?!?!?!?

Moses Lake

5. There has to be some reimbursement for what we do not just seeing client face to face. I.e. working with CPS, drug counselor, DSHS
6. Reimbursement rates for clinic and home visits needs to be examined, poor show rates are an overhead that agencies need help with. There should be some reimbursement rate for No-shows & attempted to co contact.
7. The change in the unit definition has negatively impacted staff who are working hard to meet productivity goals. The agencies productivity goals are based on the requirement to operate in the black or generating enough funds to cover the program expenses.
8. The highest risk group (TANF) women need more than 60 units and the reimbursement rate should be higher for this group. Plus contact attempts (phone calls, drop by visits) should be reimbursed. The financial return would be dollars saved with improved birth outcomes.
9. There needs to be reimbursements for no show FS visits. Nurse family partnership research shows that even the attempted client contact has a positive impact of change, esp. for our high risk clients. That phone message or card lets them know they are cared for and monitored.
10. Add enough rates up for high risk tiering to make up for no-show.
11. I'd suggest you pay us for attempted home visits AND for phone conversations of 15 minutes or more with clients (at a lower $ rate) so we can have more frequent6 contact.
12. I often feel we don't have much to offer – we are very limited by reduced funding. Sometimes is difficult to "sell" the program to eligible women. Also – due to funding, we seem to get lost in our need to see for billing rather than for patient's individual needs. (Probably our internal issues) to funding.

Burien

13. Suggestion: Pilot effectiveness of higher reimbursement rate to First Steps providers (MSS/ICM) for visits with HIGH RISK MEDICAL and TANF clients.
14. The leg needs to increase the reimbursement rate.

Lynnwood

15. Can we REVISIT reimbursement to get with FUEL increase of $.76/gal in one year and travel time, especially rural.
16. Is it possible to increase reimbursement for Home visits (perhaps for 1st screening --admit to agency visit/ then F/U reimbursement?? This would help to boost revenue for agencies that are COMMITTED to the home visit model.

17. Consider reinstating the Rule of 8's. re. unit billing.
18. Previously First Steps had a higher reimbursement rate for higher risk, i.e. chemical dependency. I strongly believe these clients are more complex and should still be at a differentiated higher rate. At our agency we only have 4 nurses and so we can only keep the highest risk (i.e. mentally ill, developmentally disabled, DV, homeless) and would help reimburse our time engaging and re-engaging these often hard to follow cases. (I've done First Steps in clinic x 4yrs and home based x5 yrs.)
19. I strongly believe we should be able to bill for jail visits (when medical coupon is reactivated.) This very high risk client is a very captive audience when they are in a "safe" environment and are not under the influence.
20. There is much in MSS & ICM that is not reimbursable including:
    a. Time spent in travel
    b. Time with documentation
    c. Follow up phone calls and
    d. Time at conferences. Is there some way to look at these costs & make them reimbursable?
21. Reimbursement: why has state taken away "rule of 8" for billing? We have lost 40 units in one clinic in one month! Due to this change.
22. HUGE CONCERN. Reimbursements for visits haven't increased in years ----though agency expenses i.e. health insurance, fuel reimbursement, cost of living increase are making it difficult to be financially viable with this program.
23. What about trying more of a lump sum/total reimbursement where we as the First Steps MSS staff can bill the total amount for very high risk/intensive and a medium/lower amount for those clients who need minimal/less checking in (i.e. we can more the reimbursement $ from one client to one who needs it more. As an experienced public health nurse, I think the government would be pleasantly surprised with our honesty and ability to utilize the resources efficiently. Thanks
24. California doesn't count BrHA as income for Military family for DSHS services. Washington needs to figure out how not to include it.

BARRIERS to ACCESSING CARE
Issues and Problems

Clients' Perceptions/Issues

Lynnwood

1. Engaging CD Moms especially meth addicts
2. Negative view of "government programs—they think we are related to CPS.
3. Voluntary ?????or program.
4. High risk clients not wanting services or limited resources for them

Community Service Offices (CSO) Issues

Lacey

1. Can a medical application for pregnancy be processed in the local offices on a time manner situation such as 10-15 days? At this time, some of the Pierce county offices and maybe other local offices are assigning this duty to the call center. They seem overloaded. Clients are getting medical coupon within a month or more time timeframe. L

Moses Lake

2. Walla Walla CSO MSW used to be scheduled 20 hrs/week in FS. She now has added responsibilities and tells me she rarely has any time to devote to FS due to other job priorities. She feels FS is being ": swept under the rug." Her question is: what has happened to the budgeted time for FS in the CSO?
3. Mattawa (Grant County) has an outstation CSO. / It is most wonderful. Medical coupons come within 1-2 weeks and can be issued the same day if there is a medical problem requiring immediate medical attention.

Burien

4. Have a release of information printed on the pregnancy medical application – Now; if we call the CSO for a client, we need to first fax a release then wait a few days for the document to be scanned into the Region 4 computers.
5. CSO's (DSHS) needs to do the medical coverage quicker so clients can get 1st trimester care.
6. Have Regional 4 CSO use Employment security data to verify income eligibility when clients don't easily have proof. (To speed up M.C. OK)
7. Educate staff at CSO call centers about MSS providers and programs. This could decrease their willingness to provide cooperative collaboration and increase cooperation and politeness.

Lynnwood

8. CSOs are not consistent with informing clients/allowing clients to take care of themselves. In King county individual workers don't know the rules.
9. Women are being told their pregnancy medical coupon expires 1 month after delivery. (I work in King county-but some in Snohomish, Pierce, Kitsap, and Island.)
10. DSHS case managers tell women they do NOT NEED First Steps MSS especially if multip.
11. Also to increase enrollment in First Steps during prenatal time would be helpful if First Steps provider could be stationed at CSO offices to enroll @ time of completing/approving Medicaid application.

Dental

Lacey

1. We are having dental coverage issues in Mason County.
    a. 1 provider only for Medicaid
    b. If not seen during pregnancy then will not see postpartum (won't do any cleaning/repairs)
    c. 3+ wait for appt.
    d. Any solutions? Many miss their chance for dental care.

Lynnwood

2. In order for a client to get to a dental appointment they must be at the clinic at 7:30a.m. to wait and see if they can be fit in. For a rural client the only option is to get a ride from the nurse who will have to pick up the client at 6:45 a.m. to get to the clinic so the client can get dental care. LW

General

1. For TANF at delivery, for a FIRST pregnancy, they were only eligible for TANF because they were pregnant. They also did not have insurance before pregnancy, just like the S-women. L
2. Spend-Down or Medicaid
    a. Pregnant women with no income: have partners, boy friends or husbands with high income due to seasonal jobs. As soon the season is over, pregnant women qualify for MSS and Medicaid. Are you considering only income from mother or the couple? Or the parents' income when we have a minor who is pregnant? L (Community Health care)
3. In the "Passport" program, for children in Foster care, the nurse has access to Medicaid billing records. DSHS employees have access to this info. Even though billing may be later than the 9 month pregnancy, there still may be info available about multiple billers for FS services that could be connected with each other for coordination of care. What is the time lapse between when a client APPLIES for a medical coupon for pregnancy (eligibility review) and receives their medical coupon? Sometimes it seems to take 1-2 months. During that time they are unable to get medical care. ML (BFC – CSO in Kennewick)
4. High case loads---documentation on paper are barriers. LW
5. High case load and increased amount of paperwork. LW

Healthy Options and/or other Insurance

Spokane

1. A huge problem is that clients may be enrolled in a Healthy Options plan and have prenatal or pediatric prodders in place. For some reason they receive notification that their H.O. plan has been changed…jeopardizing their ability to obtain postpartum, family planning, or well baby care. It's crazy! It also affects newborns with medical issues who need a pediatrician but who are switched to H.O. plans that only family practice physicians accept. It means delay of 2-3 months in accessing care.

Burien

2. Pregnant women are given the freedom to choose their clinic & provider, but the problem is: their assigned insurance is being switched to another insurance almost 2 or 3 times during their 9 months prenatal care. Example: CHPW changed to Molina (2-3x) very frustrating.

Lynnwood

3. Universal Healthcare is a right not a privilege!
4. A HUGE issue for our clients is that they get switched without asking from one managed care plan to another without asking. This disrupts prenatal care and money loss for the clinics.

Identifying/Finding clients

Spokane

1. Have grant CSO access to client registry—FS providers have access to it.
2. Random thought – some sort of computer program through CSO to view who (client) is assigned to which First Steps to avoid duplicate services.

Interpreters

Lacey

1. Availability of interpreters does impact timing of visits. Interpreters are hard to get and not very reliable. (Paratransit)
2. Clients have no interpreters available at OB's office. Guess it's an issue in No. County also!
3. Help!!! I am having a tough time finding a Spanish counseling staff that accepts an open medical coupon for pregnancy coverage. I have called SeaMar clinic in Pierce, Catholic Community services, a staff from RSN, DSHS local and Ol7ynpia and others that I can't recall at this time. They're all stating that an open medical coupon does not pay for counseling.

Moses Lake

4. Solutions focus: more meeting for cultural competence and language. MIXTECO 60% -- combination of 10 dialects.
5. Adams county—Mix-Teco not Spanish 50% of Othello. Language barrier!
6. They (interpreters) decline to go on a home visit. I must give 48 hour notice for postpartum visit. A week is preferred for the other appt. I have interpreter who will not speak what I've said.
7. To help our program have quality, consistent interpreter services, some reimbursement for in-house interpreters should be provided.
8. I am a bilingual BHS. I often go with the MSS nurse on visits so I can interpret for her and I can do my own BHS visit at the same time. This is a very effective visit for us (and the client) but currently after a 1 ½ hour visit I am only able to bill 3 units and the nurse can only bill 3 units. Therefore, we receive no reimbursement for interpretation needs and we're also only paid for half of our time as professionals. This doesn't seem fair to me.
9. Obstacles to care: the interpreter services as designed are difficult to use for agencies.

Burien

10. In both King and Snohomish county working with translation is an increasing need with population shift.
11. Sometimes they (interpreters) don't show up and we can't bill or see client. If we have a good, reliable interpreter, we can't regularly get her because Hopelink and Paratransit don't allow requests.
12. Also is an issue for initial visit because they don't go out without a PIC #. It delays access to care and costs the agency for hiring interpreter for initial application visit.
13. Pierce County. Many times both Paratransit transportation and Paratransit interpreters' services do request our agency to verify the clients' medical coupon by faxing it even though they have had their coupon for MONTHS.
14. One of the barriers involves the interpreter services (Paratransit) being unavailable or cancelled pt. the last minute.

Lynnwood

15. Sometimes I reschedule 2 or 3 times due to interpreter not showing up or could not fulfill my agency's request.
16. Obtaining interpreters services has many obstacles to being efficient and easy to access. I would like to have an interpreter for a day so there is flexibility in the schedule.

Jail

Lacey

1. When pregnant or parenting women are in jail they lose the medical coupon. Our county can not afford to pay for medical care let alone MSS/ICM for them. How can they retain Medicaid/first steps?

Mental Health/ Screening for Depression

Lacey

1. Best care practices. When medical coupons. /MSS services end and client does not access care. Treating clients for depression through MSS services.
2. Women needing counseling due to history of depression/MH issues, current depression, and PPD; may not get into counseling due to waiting lists of providers and may not get in until coupon is no longer active so provider will not take them due to no coupon. Also some women become depressed after coupon has expired.
3. This has come up in EVERY meeting I have been to. Biggest surge in PPD comes @ 3 months pp. Coupon is expired, NO SERVICES AVAILABLE! We are supposed to screen but NOTHING available to help Moms!! Couldn't we bill under ICM since a depressed Mom has direct effect on infant health well-being?!

Burien

4. How to find resources for post partum mood disorder - providers in Pierce County. Minimal # of known providers.
5. State needs to increase access to mental health services and improve quality of mental health services.
6. Very limited psych resources. Those that take med coupons are very full. At community Mental Health agencies – clients must be "tiered." What about women with PP depr4ession (who's not psychotic.)

Lynnwood

7. Mental health concerns with limited community resources to serve mental health needs.
8. When women lose custody of their kids, they lose their medical coupon and cannot access mental health treatment. They often do not meet GAX criteria--Which can effect reunification. Can they keep a coupon unless they lose parental rights? Ruth Kagi go $6 million allocated for this thru DCFS court order. It's not coming down and won't cover meds anyway.

OB Provider Access Issues

Lacey

1. Grays Harbor County has a lack of providers that lack the4 accessing interpreter services.
2. Since June '07 the OB providers in Pacific county are not seeing pregnant women until 12 weeks gestation. This is a huge barrier to 1st trimester care!
3. OB's office first contact with pregnant woman by telephone. 2nd with nurse, third; doctor sees first time.

Spokane

4. I don't understand why an OB provider wouldn't want to see a client on "straight" DSHS (before they get a Healthy Options Provider)--? Is the fee-for service rate so different?!

Moses Lake

5. Lack of OB appointments available. Yakima County. Possibly low Medicaid reimbursement?
6. A more comprehensive seamless flow would be very great in our community. AN OB provider who makes verbal and written referral since many clients respect OB provider's suggestions.
7. Slow access to OB provider and MD availability.
8. Teenage lack of awareness and innate barriers. Therefore community/school education needed.
9. Providers may be reaching their ceiling in ability to accept Medicaid coupons and financially remain solvent. (this includes physicians as well as mental health professionals) Probably a reimbursement rate issue.
10. If younger women tend to enter prenatal care later, it would be good to explore alternative ways to deliver OB care---i.e. school-based clinics??
11. There doesn't seem to be a problem of OB shortage. Our women easily get their first appointment.

Burien

12. Liability insurance limits. FP MD's –so many no longer providing OB care – increased pt. load for OB/Gyn – increases burn out of OB/GYN PROVIDERS. All clients are having difficulty getting care.
13. Regarding the comment on providers who do not accept Medicaid and $...C/S rates Washington state are 17.3% Medicaid + 26.7% non-Medicaid. Nearly 2 times as much. M/B R/T patient request of C/S?

Lynnwood

14. If WIC can qualify pregnant women with a presumptive eligibility for one month why not the same system for pregnancy medical?
15. "Everett Clinic" has taken over several private practice clinics. They have a strangle hold on medical care in Snohomish county and traditionally have limited or refused to care for pregnant women who are not insured, i.e. Medicaid & non-citizens.
16. Lack of PNC providers.
17. We have only 2 clinics serving 85% of our client base in Benton/Franklin counties. Our OB/GYNs are inundated with patients. They are SITTING in waiting rooms for 2 hours. Women are losing babies in 1st trimester due to lack of access EARLY!

18. Lack of prenatal providers in Snohomish county—south Snohomish county. Women are not getting appts. Until after 22-26 weeks.
19. Snohomish County—2 women in 17 weeks gestation (Dec. 11, 07) their first prenatal care appointment will be first week in February.
20. Snohomish County—(central – Everett) access to Everett Prenatal Care Providers:
    a. No med. Coupons –can't get appt.
    b. Too few providers to take all pregnant women
    c. Prenatal providers leaving their practice
    d. Navy population brings in partners who are pregnant
    e. High risk pregnant women can't get appts. For 2 months and even if call by PHN can't even get into PNC for 1 month
    f. Constant increase in population
21. It's not just prenatal care that needs to be provided but DELIVERIES at the end of the pregnancy. So getting those women into prenatal care is complex if Provider numbers also need to go up for on-call for deliveries.
22. Shortage of prenatal care providers because increased volume of pts. Burned out providers leaving practice, increased growth overall and malpractice.
23. Pediatrician care access in Snohomish County is extremely limited because providers aren't accepting Medicaid clients. Decrease in access. Community Health clinic won't schedule well child checks and many clients don't get immunizations on time.
24. Prenatal care access is about 2 months out for initial appointment for OB care in Snohomish Co.
25. Ballard/Swedish – (King county) 2-3 weeks to get an initial appt access to care includes Swedish midwives (Swedish) north Seattle women's specialists (OB/BYN)
26. Many family practice doctors don't do prenatal care anymore.
27. Swedish physicians' network no longer accepts Molina Health Care because the reimbursement rates are so low, their practices get overrun with Medicaid clients and they feel they can't afford them.
28. One of the largest OB provider groups has two OB-close new OB for extended period of time.
29. Need to increase acceptance and #s of RN midwife to deliver non-complicated women. MDs refuse to utilize them.
30. Came to First Steps from hospital OB in south Snohomish County. Since I left First Steps 10 years ago and now came back and know for a fact the # of OBs delivering at Stevens Hospital is less than ½. In 1998=Valley Medical OB in Lynnwood (gone). OB providers from CHC (4-5) now no longer do deliveries. Sound Women's Care – several OBs retired, less able to take clients. Mill Creek FP no longer doing OB. Edmonds Family Med – Limited OB care – zero high risk, zero Medicaid. One of the main problems – high cost of insurance for OBs. Due to high cost of living – this area not conducive to new MDs.
31. In response to the medical clinics saying they are so busy it's hard to get clients in. Why is it when you call to set up a woman with prenatal the first question is "what insurance do they have" then they decide when they can see them. One client this week was told she can't be seen until Feb. 1st—she will be 27 weeks (Everett)
32. Problem in Snohomish county—zero providers. The community health centers (especially CHC) system has struggled to recruit/retain medical providers for OB care. Other OB providers limit the #s of women they care for. The quota system that providers have to

follow (seeing X number of clients per day) is burning providers out!! Snohomish County has increased rate of growth.

33. Lack of providers. Women not getting prenatal care until 16-20 weeks gestation, especially in Snohomish County.
34. We have found several clients that have not seen a doctor until 20+ weeks into their pregnancies in Snohomish County.
35. Physicians leaving communities due to high liability insurance—in Whatcom County, Mt. Baker Family Med. Was forced to close due to inability to obtain affordable clinic liability insurance.
36. In Kitsap County, OBs won't see client until medical coupon is in hand, thus delays early 1st trimester access.

Provider Agency

1. Poor management, unsupportive non-nursing management.

Transportation

Lacey

1. Paratransit refuse to transport client that are on the bus line-no matter whether reasons are such as new in the area, illness, etc. How can I get over this hurdle? Otherwise client just see their Dr. whenever husband or partner is able to transport them.
2. Bus tickets available for clients to get to appointments until their DSHS is approved and they can get a buss pass.

Moses Lake

3. Mailing buss passes
4. Increase available units available for HR preg.
5. Ritzville, Lind Washington home to travel to Spokane-Tri-cities and Moses Lake. Special mobility services will only transport to closest OB which is a barrier some women want to go to certain OBs that aren't as close.
6. We should/could train and share our 'secrets' of how we "get around" system barriers. i.e. Transportation Tips and Tricks"
7. Special Mobility Services—SMS needs verification and reason of why transportation is needed. They need a fax from Dr. they are going to go see. That is time consuming for provider and to get things completed for client. SMS should verify that we are a provider and take info from us if truth is an issue. SMS issues a minimum amount of gas that client has to use up before calling to ask for another gas voucher. Even if the visit is local for client.

Burien

8. In very rural areas of East Pierce county who are 8-20 miles from the nearest bus. How do they get to medical, WIC or MSS appointments? B
9. This is a Metro issue and not ONE MORE THING for First Steps to absorb.
10. Pierce County. Many times both Paratransit transportation and Paratransit interpreters' services do request our agency to verify the clients' medical coupon by faxing it even though they have had their coupon for MONTHS.
11. Hopelink transportation is only offered to medically high risk mothers prior to 36 weeks of pregnancy. It should be offered throughout pregnancy.
12. The Hopelink bus pass is offered only during the first 2 weeks if the month prior to the month in which it is requested. Also they require a client to have at least 3 medical appointments in the month for which the pass is requested. This is not feasible, as appointments like ultrasounds are scheduled with much less anticipation.
13. Hopelink should offer exceptions and allow us to schedule trans for women who need the taxi when they are experiencing social or environmental circumstances that make it necessary.
14. I'm often told by client they are not eligible for buss pass. Month to month eligibility is what is showing on their system.
15. Bus Pass – barriers to obtaining # appts/month. Call month in advance (yet don't receive until 1st of the month)
16. Bus pass/taxi services – not available in the same month.
17. Can't get until 36 weeks pregnant. IS this because of need to have at least 3 visits/month in order to get the bus pass?
18. ICM Moms need bus tokens bus pass, too!!

Lynnwood

19. Whatcom County—Our clients are told the bus will only run on Tuesday and Thursday for appts. More days/runs are needed! We have been successful on rare occasions to convince a pick-up on another day but most of our clients cannot advocate as well for themselves.
20. More female drivers so women feel safe. WorkFirst can train women to be drivers.
21. In order for a client to get to a dental appointment they must be at the clinic at 7:30a.m. to wait and see if they can be fit in. For a rural client the only option is to get a ride from the nurse who will have to pick up the client at 6:45 a.m. to get to the clinic so the client can get dental care.
22. Transportation to Harborview from outside the Seattle area is a problem. Hopelink (Medicaid) doesn't want to pay for taxi transport – but patients want to come due to our Somali interpreters & past experience at Harborview. The patients are also getting switched (somehow) to other places closer to home.
23. Poor routing of buses. Asking pregnant women and children to use bus when they must walk long and dangerous distances to access.

WorkFirst

Burien

1. Include participation with MSS/ICM as part of WorkFirst contract.

Lynnwood

2. TANF women are required to do WorkFirst activities and requirements are not relaxed for pregnancy.

WIC

Burien

1. When I send my clientele to WIC I ask them to tell WIC that they are already receiving MSS. WIC has told my clients that they are still required to see the RD at least once. Why is this? I am an RD
2. When my established MSS client goes to WIC; even if she tells WIC she is already receiving MSS, they say she is required to see their dietician and sometimes provide other MSS.
3. I had a client who I was with for an appt. I called WIC to help her set up an appt. with WIC. I explained to the receptionist that my client was receiving MSS through our agency and she would be WIC only. I was told that the appt. would be almost 2 months out. I asked if she could get in sooner if she were not receiving MSS and could receive it from WIC. She told me she could get her in w/in the month. I handed the phone to my supervisor at this point. My supervisor was told that they only accept so many Non-MSS WIC clients.